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IN THE

Supreme Court of the United States

October Term, 1980

TEMPLE UNIVERSITY—OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION and THE HOSPITAL ASSOCIATION OF PENNSYLVANIA,

Appellants

v.

COMMONWEALTH OF PENNSYLVANIA, DEPARTMENT OF PUBLIC WELFARE and HELEN O'BANNON,

Appellees

On Appeal From the Supreme Court of Pennsylvania

JURISDICTIONAL STATEMENT

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QUESTION PRESENTED

Whether, under Title XIX of the Social Security Act and the equal protection clause, a state Medical Assistance program may refuse to pay for necessary medical care in a category of care required to be included in such a program.

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Appellants

v.

COMMONWEALTH OF PENNSYLVANIA, DEPARTMENT OF PUBLIC WELFARE and HELEN O'BANNON,

Appellees

ON APPEAL FROM THE SUPREME COURT OF PENNSYLVANIA

JURISDICTIONAL STATEMENT

Temple University—Of the Commonwealth System of Higher Education ("Temple University") and The Hospital Association of Pennsylvania, the appellants, appeal from the judgment of the Supreme Court of Pennsylvania entered on June 19, 1980 holding that Pennsylvania Medical Assistance Regulation 9421.74(q) does not violate the equal protection clause of the Fourteenth Amendment to the United States Constitution, Title XIX of the Social Security Act or the regulations thereunder.

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OPINIONS BELOW

The opinion of the Supreme Court of Pennsylvania has been reported at 415 A. 2d 413 (Appendix A1). The final opinion of the Commonwealth Court of Pennsylvania was reported at 47 Pa. Commw. Ct. 22 and 407 A. 2d 92 (Appendix A2). An earlier opinion of the commonwealth court in this action was reported at 30 Pa. Commw. Ct. 595 and 374 A. 2d 991 (1977).

JURISDICTION

This action in equity was filed as an original action in the Commonwealth Court of Pennsylvania. The judgment of the Supreme Court of Pennsylvania was entered on June 19, 1980 and the notice of appeal was filed on September 15, 1980, within 90 days of that date. This Court's jurisdiction is invoked under 28 U. S. C. § 1257(2).

QUESTION PRESENTED

Whether, under Title XIX of the Social Security Act and the equal protection clause, a state Medical Assistance program may refuse to pay for necessary medical care in a category of care required to be included in such a program.

CONSTITUTIONAL PROVISION INVOLVED

Fourteenth Amendment, United States Constitution:

[N]or shall any state . . . deny to any person within its jurisdiction equal protection of the laws.

STATUTES INVOLVED

42 U. S. C. § 1396a(a)(13)(D):

(a) A State plan for medical assistance must—

* * *

(13) provide—

* * *

(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1320a-1 of this title, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1395x(v) of this title as the reasonable cost of such services for purposes of subchapter XVIII of this chapter.

REGULATIONS INVOLVED

42 C. F. R. § 440.230 (1979):

Sufficiency of Amount, Duration and Scope

(a) The plan must specify the amount and duration of each service that it provides.

(b) Each service must be sufficient in amount, duration and scope to reasonably achieve its purpose.

(c)(1) The medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.

(2) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

Section 9421.74(q) of the Pennsylvania Medical Assistance Regulations:

Except as noted below, Medical Assistance payments are not made to hospitals either for specific noncovered services and procedures or for prolonged hospitalization which is not medically justified.

* * *

Prolonged hospitalization includes extended hospitalization for:

* * *

(q) Patients who no longer require acute patient care. However, the Department will make payment to the hospital for skilled nursing or intermediate care provided for a patient in a certified bed in a certified and approved hospital based skilled nursing or intermediate care unit. 7 Pa. Bulletin 2180 (August 6, 1977).

STATEMENT OF THE CASE

This class action was filed in the Commonwealth Court of Pennsylvania in 1976 by Temple University [1] as the operator of Temple University Hospital and a participant in the Pennsylvania Medical Assistance program, and by The Hospital Association of Pennsylvania. That program provides payment for medical care, including inpatient hospital care, to the indigent and receives federal financial assistance under Title XIX of the Social Security Act. 42 U. S. C. § 1396 *et seq.* (Supp. 1979); Pa. Stat. Ann. title 62, § 443.1(1) (Purdon). The defendants were the Pennsylvania Department of Public Welfare and its Secretary, Helen O'Bannon.

The action sought an injunction against the defendants' longstanding practice of not paying for inpatient hospital care provided to patients who were medically ready to leave the hospital but who were unable to do so because they required nursing home care and there was no nursing home bed available. The current regulation to that effect is Regulation 9421.74(q), effective August 15, 1977.

The issues in this action are the validity of Regulation 9421.74(q) under state and federal law including, in par-

1. Temple University operates a major inner city teaching hospital with the largest volume of Medical Assistance inpatients in Pennsylvania. The legal effect of the Pennsylvania Regulation at issue in this case is to transfer responsibility for payment from the Department of Public Welfare to the patient; the practical effect, in virtually every case, is to deny payment to the hospital. Thus, the commonwealth court held that Temple University, as a subrogee of its patients, had standing to assert their rights. 30 Pa. Commw. Ct. at 604, 374 A. 2d at 996. *See also Memorial Hospital v. Maricopa County,* 415 U. S. 250 (1974). Temple University's standing was not challenged before the Pennsylvania Supreme Court.

ticular, under Title XIX of the federal Social Security Act.[2] and the equal protection clause of the Fourteenth Amendment.[3] Plaintiffs' argument has been essentially that Regulation 9421.74(q) is invalid because it prevents payment to hospitals for inpatient care which is medically necessary and which hospitals must provide. The defendants' rejoinder was that the federal financial assistance under Title XIX was not available for such care and that, in any case, the Regulation permits payment to a hospital for care rendered to a patient in a hospital-based nursing home, *if* the hospital has one and *if* that nursing home has an appropriate vacancy.

After the Department of Health, Education and Welfare ruled that federal financial assistance was available, the plaintiffs moved for summary judgment arguing that the remaining issues were purely legal. The commonwealth court, in an opinion addressing plaintiffs' substantive arguments, denied plaintiffs' motion. Although the defendants had not moved for summary judgment, the commonwealth court entered judgment in their favor. (Appendix A8).

Plaintiffs appealed to the Supreme Court of Pennsylvania, which affirmed *per curiam*. (Appendix A1). Thus, the Pennsylvania courts have held Regulation 9421.74(q)

2. The issue of the conformity of Regulation 9421.74(q) with federal law was raised by the defendants at paragraphs 40-51 of their New Matter, filed at the same time the Regulation was promulgated, and was passed on by the commonwealth court in its final decision. (Appendix A7). Plaintiffs argued the issue to the supreme court at pages 16 through 19 of their brief.

3. Plaintiffs' complaint alleged, at paragraphs 33 through 35, that the Department's 1976 regulation violated the equal protection clause. The issue as to Regulation 9421.74(q) was argued on summary judgment to the commonwealth court and ruled upon by that court. (Appendix A6). Plaintiffs renewed their argument at pages 20 through 24 of their brief to the supreme court.

to be valid as against a challenge to its validity under both the United States Constitution and federal law. Because the Regulation was promulgated by the Department of Public Welfare pursuant to delegated legislative authority (Pa. Stat. Ann. title 62, §§ 201, 443.1(1) (Purdon)), review by the Court is by appeal under 28 U. S. C. § 1257(2). *See Atchison, Topeka & Santa Fe Ry. Co. v. Public Utility Commission of California*, 346 U. S. 346 (1953).

THE QUESTION IS SUBSTANTIAL

This appeal involves a question of central importance to the 49 states and the District of Columbia which receive federal financial assistance under Title XIX of the Social Security Act for medical assistance programs, to the over nine million recipients who receive over $18 billion in annual benefits under those programs,[4] and to the entire health care industry.

That question, on which this Court has never ruled, is whether a state medical assistance program can exclude from coverage necessary medical care in a category of care required to be included under Title XIX.[5] Two state

4. U. S. Bureau of the Census: *Statistical Abstracts of the United States 1979* (100th ed. Washington, D. C. 1979), Figures 557 and 558 [hereinafter "*Statistical Abstract*"].

5. This Court has previously ruled only on unique issues affecting a relatively small portion of the medical assistance beneficiaries and thus only a small portion of the potential medical assistance benefits. *See, e.g., Williams v. Zbaraz*, — U. S. —, 100 S. Ct. 2694 (1980); *Harris v. McRae*, — U. S. —, 100 S. Ct. 2671 (1980); *O'Bannon v. Town Court Nursing Center, Inc.*, — U. S. —, 100 S. Ct. 2467 (1980); *Beal v. Doe*, 432 U. S. 446 (1977); *Maher v. Doe*, 432 U. S. 464 (1977); *Memorial Hospital v. Maricopa County*, 415 U. S. 250 (1974). The present appeal affects the rights of all of the beneficiaries and a substantial portion of the benefits paid.

supreme courts to which the question has been presented have issued directly contrary rulings. In addition, at least one federal court of appeals has issued an opinion on a related question which is contrary to the decision below.

Title XIX provides federal financial assistance to state programs providing medical care to the indigent. 42 U. S. C. § 1396 *et seq.* In order to qualify for federal assistance, a state program must provide five categories of care, including "inpatient hospital services". 42 U. S. C. §§ 1396a(a)(13)(B) and (C), 1396a(a)(17) and 1396d (a)(1).[6] However, by its Regulation 9421.74(q), Pennsylvania has determined that it will not pay for inpatient hospital care rendered to patients who are medically ready for discharge from a hospital to a nursing home and who cannot be discharged because there is no nursing home bed available. In other words, when a patient is medically ready to leave a hospital, Medical Assistance payment stops and the hospital must bear the burden of care caused by any shortage of nursing home beds. The Commonwealth Court of Pennsylvania, in an earlier action between Temple University and the Department, decided that "[i]n such circumstances there is still a medical necessity for the hospital services" and that to deny payment "would not further the purpose of the utilization review procedure". *Commonwealth of Pennsylvania, Department of Public Welfare v. Temple University—Of the Commonwealth System of Higher Education,* 21 Pa. Commw. Ct. 162, 166, 343 A. 2d 701, 704 (1975).

A state program which excludes from coverage necessary inpatient hospital care raises two federal questions:

6. The other required categories are outpatient hospital services, laboratory and x-ray services, skilled nursing facility services, early screening and diagnosis services, family planning services and physicians' services. 42 U. S. C. § 1396d(a). These services involved expenditures of $11.7 billion in fiscal 1978. *Statistical Abstract, supra,* note 4, Figure 558.

(1) "Serious statutory questions" which this Court specifically left unresolved in *Beal v. Doe*, 432 U. S. at 444.[7] Under Title XIX, a medical assistance program must include inpatient hospital care "sufficient in amount, duration and scope to reasonably achieve its purpose", must pay the reasonable cost of such care and may not reduce the duration of that care because of "diagnosis, type of illness or condition". 42 U. S. C. § 1396a(a)(13)(B), (C) and (D); 42 C. F. R. § 440.230(b) and (c).

(2) Serious questions under the equal protection clause of the Fourteenth Amendment because the exclusion of necessary inpatient hospital care means that some medical assistance beneficiaries are covered while others, in the same circumstances, are not. For example, in the present case, the Pennsylvania Medical Assistance program distinguishes (a) between patients in nursing homes and those in hospitals who have the same medical condition and who seek and require the same medical services and (b) between two classes of patients, each of which medically requires inpatient hospital care. Pennsylvania cannot refuse to pay "benefits necessary to basic sustenance" solely on fiscal grounds. *Memorial Hospital v. Maricopa County*, 415 U. S. at 263.

The question raised by this appeal is important not only because of the size of medical assistance programs and the number of persons who rely on them, but also because of the public interest in the costs and burdens of providing health care. Total medical assistance payments have increased from approximately $7 billion in calendar

7. This Court was not required to resolve these questions in *Harris v. McRae*, — U. S. —, 100 S. Ct. 2671 (1980) or in *Williams v. Zbaraz*, — U. S. —, 100 S. Ct. 2694 (1980) because of its conclusion that the Hyde Amendment constituted an amendment of Title XIX.

year 1972 to approximately $18 billion in fiscal year 1978.[8] "The soaring cost of medical assistance programs is a matter of national concern . . . ." *White v. Beal*, 555 F. 2d 1146, 1149 (3d Cir. 1977). Concern for these costs has led to reductions in the coverage of medical assistance programs.[9] This Court should make a definitive statement of the legal standard which states must use in determining which services they are required to provide.

The narrow question presented by this appeal is itself important because the supreme courts of two states have issued inconsistent rulings. The Pennsylvania court in this action ruled that Pennsylvania need not pay for inpatient hospital care rendered after the patient was medically ready to be discharged, but only to a nursing home, even if there was no available nursing home bed. In contrast, the Supreme Court of New Jersey, in *Monmouth Medical Center v. State*, 80 N. J. 299, 403 A. 2d 487, *cert. denied*, 444 U. S. 942 (1979), concluded that the New Jersey regulation prohibiting payment for inpatient hospital care under precisely the same circumstances violated Title XIX and 42 C. F. R. § 440.230(b).[10] Although the

8. Statistical Abstracts, *supra*, note 5, Figure 558.

9. During the nine months from October of 1975 to June of 1976, eighteen states reduced or temporarily cut back medical assistance coverage. *Data on the Medicaid Program: Eligibility, Services, Expenditures, Fiscal Years 1966-1977*, Prepared by the Staff for Use of the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce, U. S. House of Representatives, March 1977, Table 5. During the first six months of 1978, six states did so. *Data on the Medicaid Program: Eligibility/Services/Expenditures*, 1979 Edition (Revised) U. S. Department of Health, Education and Welfare, Medicare/Medicaid Management Institute, Table 5.

10. "[W]e conclude that the State regulation here at issue is unreasonable and hence invalid even under the State's interpretation of federal requirements." 80 N. J. at 309, 403 A. 2d at 492.

New Jersey regulation does not mention hospital-based nursing homes, New Jersey, like Pennsylvania, permits reimbursement for the care they provide.[11]

The Pennsylvania Supreme Court decision is also inconsistent with a decision of the Third Circuit Court of Appeals. In *White v. Beal*, 555 F. 2d 1146 (1977), that court invalidated, under Title XIX, a Pennsylvania Medical Assistance regulation stating the medical conditions for which the program would pay for eyeglasses, holding: "The state plan's classification is arbitrary since it is based upon a factor not reasonably related to the medical need." 555 F. 2d at 1151.[12] The regulation at issue in *White* limited the coverage of the Pennsylvania program in a category of services not required by Title XIX. If a state cannot limit coverage in an optional category except on a basis related to medical need or utilization control, it cannot *a fortiori* do so in a required category. Thus, an inde-

11. Section 10:63-1.2 of the New Jersey Administrative Code provides that an eligible "intermediate care facility", "long-term care facility" and "skilled nursing facility" include identifiable parts of larger institutions. Counsel has confirmed, by a telephone conversation with Joanne Gibson, Esq. of the New Jersey Department of Human Services on September 10, 1980, that there is at least one "hospital-based" nursing home in New Jersey which receives medical assistance payments.

12. Other federal courts of appeals have similarly held that a state must select the services to be included in a medical assistance program on the basis of medical need. *Hodgson v. Board of County Commissioners*, 614 F. 2d 601 (8th Cir. 1980); *Zbaraz v. Quern*, 596 F. 2d 196 (7th Cir. 1979); *Preterm, Inc. v. Dukakis*, 591 F. 2d 121 (1st Cir.), *cert. denied sub nom., Preterm, Inc. v. King*, 441 U. S. 952 (1979). On the other hand, certain federal district courts have ignored medical need in cases involving the scope of medical assistance programs. *Virginia Hospital Association v. Kenley*, 427 F. Supp. 781 (E. D. Pa. 1977); *District of Columbia Podiatric Society v. District of Columbia*, 407 F. Supp. 1259 (D. D. C. 1975).

pendent reason why this Court should note probable jurisdiction is to resolve directly conflicting rulings of two state supreme courts and to resolve a conflict between a state supreme court and a federal court of appeals on the standard under which a state can exclude services from a medical assistance program.

In stating the issue presented by this appeal, we have been mindful of the arguments of the appellees that Regulation 9421.74(q) is valid because it permits payment to a hospital for care provided in a hospital-based nursing home and the statement of the commonwealth court that the Regulation relates merely to the manner of reimbursement.[13] (Appendix A5). We believe that neither addresses plaintiffs' objection to the Regulation nor supports the actual holding of the Pennsylvania courts. Specifically:

1. This action challenges Pennsylvania's Regulation only to the extent that it prohibits payment for inpatient

13. A medical assistance program cannot pay for care in the acute care facilities of a hospital at the rate approved for nursing homes. In order to be eligible for payment at a nursing home rate (either skilled care or intermediate care), a hospital-based facility must be a distinct part which meets separate requirements and is separately licensed. 42 C. F. R. §§ 440.40, 440.150. Moreover, in order for a hospital to receive payment for the reasonable cost of inpatient care, it must receive payment at the full inpatient rate for all days. The reason for this is that Medical Assistance pays for each inpatient day at a rate equal to the average cost for all inpatient days. The effect of this formula can be demonstrated by a simple mathematical example. If a hospital had only two inpatients, one receiving acute care at a cost of $300 per day, and one awaiting transfer to a nursing home whose care cost $100 per day, its total cost per day would be $400 and its average daily cost per inpatient would be $200. Under the Medical Assistance program, the hospital would receive $200 for the first (*i.e.*, acute care) patient. In order to receive full payment for both patients, it would have to receive $200 for the second (*i.e.*, the one awaiting transfer).

hospital care when a patient remains hospitalized because no nursing home bed is available. Appellees concede that the Regulation has this effect. A premise of the challenge is that, from time to time, a nursing home bed *is not* available. It is no answer to state that the Department of Public Welfare will pay for care in a nursing home if a nursing home bed *is* available.

2. The defendants' argument, and the statement of the commonwealth court, assume (a) that every hospital could establish a hospital-based nursing home and (b) that, if it did, it could obtain reimbursement for all of the patients whom it is unable to discharge because a nursing home bed is not available. A myriad of factual issues is covered by these assumptions.[14] In support of their posi-

14. Among these assumptions are the following:

1. The hospital has the physical resources to establish a nursing home. A hospital-based nursing home must be either a distinct portion of the hospital or "on the immediate grounds of" the hospital. Pennsylvania Medical Assistance Regulations 9424.6(1)(b) and 9425.12(b); 9 Pa. Bulletin 428 (February 3, 1979).

2. The hospital has the financial resources to establish a nursing home. It is well recognized that many private non-profit hospitals are in precarious financial straits. *See Memorial Hospital v. Maricopa County*, 415 U. S. at 264.

3. The hospital's proposal for a nursing home would be found to be satisfactory by all of the regulatory agencies and such agencies, including the local health planning agency, the state Department of Health, the state Department of Labor and Industry, the state Department of Public Welfare and the federal Health Care Financing Administration, would grant the required approvals. In order to obtain the maximum reimbursement for its nursing home services, the hospital must substantiate to the Department of Public Welfare that it is economically feasible to operate distinct part skilled nursing and intermediate care facilities. Pa. Medical Assistance Regu-

tion, the defendants offered only the fact that 29 out of the 270 hospitals participating have established nursing homes under the defendants' former regulations. *See* Appendix A6. This scanty evidence did not provide the commonwealth court or the supreme court with any basis to make findings of fact on any of the issues raised and neither did so. Thus, in holding Regulation 9421.74(q) valid as applied to a class of hospitals participating in the Pennsylvania Medical Assistance program, the Pennsylvania courts have determined that a Medical Assistance program, under state and federal law, need not provide inpatient hospital care whenever it is medically required and that a Medical Assistance program could refuse to pay for such care when nursing home care was appropriate but unavailable.

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14. (Cont'd.)

lations 9424.7121 and 9425.9111; 8 Pa. Bulletin 2828, 2831 (October 14, 1978).

4. The hospital could continue to comply with all of the many regulatory requirements for nursing homes. *See, e.g.*, 42 C. F. R. §§ 405.1101-405.1137; Pennsylvania Medical Assistance Regulations 9424.6 and 9425 and 28 Pa. Code Chapter 201. The complexity of these requirements and the difficulty in meeting them was a factual premise of this Court's decision in *O'Bannon v. Town Court Nursing Center*, — U. S. —, 100 S. Ct. 2467 (1980).

5. There would be vacancies in the hospital-based nursing home at the appropriate time. In order to be eligible for medical assistance reimbursement, a nursing home in Pennsylvania must be open to the general public. Pennsylvania Medical Assistance Regulations 9424.6(1)(b) and 9424.12(1)(b). In areas where there is an acute shortage of nursing home beds (*e.g.*, Philadelphia and Pittsburgh) it is highly probable that a hospital-based nursing home would be full most, if not all, of the time.

6. The vacancy would be in a bed certified for the appropriate level of care for the patient involved, *i.e.*, skilled nursing or intermediate care.

CONCLUSION

For the reasons stated above, this Court should note probable jurisdiction of this appeal.

Respectfully submitted,

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[J. 255]

IN THE

SUPREME COURT OF PENNSYLVANIA

MIDDLE DISTRICT

No. 68 May Term 1979

Appeal From the Decree of the Commonwealth Court at No. 1171 C. D. 1976

Entered: November 21, 1979

TEMPLE UNIVERSITY OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION and THE HOSPITAL ASSOCIATION OF PENNSYLVANIA, on behalf of itself and themselves and all others similarly situated,

Appellants

v.

PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE and HELEN B. O'BANNON, SECRETARY, PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE,

Appellees

OPINION

(Filed June 18, 1980)

PER CURIAM:

Decree affirmed.

Each party to pay own costs.

Mr. Justice Nix took no part in the consideration or decision of this case.

Mr. Justice Larsen dissents.

IN THE
COMMONWEALTH COURT OF PENNSYLVANIA

No. 1171 C. D. 1976

TEMPLE UNIVERSITY—OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION AND THE HOSPITAL ASSOCIATION OF PENNSYLVANIA, ON BEHALF OF ITSELF AND THEMSELVES AND ALL OTHERS SIMILARLY SITUATED,

Plaintiffs

v.

PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE AND HELEN B. O'BANNON, SECRETARY, PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE,

Defendants

BEFORE:

HONORABLE JAMES S. BOWMAN, President Judge
HONORABLE ROY WILKINSON, JR., Judge
HONORABLE THEODORE O. ROGERS, Judge
HONORABLE GENEVIEVE BLATT, Judge
HONORABLE RICHARD DiSALLE, Judge
HONORABLE DAVID W. CRAIG, Judge
HONORABLE JOHN A. MacPHAIL, Judge

ARGUED: September 11, 1979

OPINION

(Filed October 26, 1979)

OPINION BY JUDGE BLATT

Temple University and the Hospital Association of Pennsylvania (plaintiffs) initiated this equity action against the Department of Public Welfare (DPW) seeking to enjoin the implementation of certain DPW regulations. We have previously disposed of the DPW's preliminary objections, *Temple University v. Department of Public Welfare,* 30 Pa. Commonwealth Ct. 595, 374 A. 2d 991 (1977) (*Temple II*), and before us now is the plaintiffs' motion for summary judgment.

Specifically at issue is the DPW's policy regarding the reimbursement of hospitals for expenses incurred in caring for Medical Assistance patients for whom some care is necessary but for whom acute care in a hospital is unnecessary and for whom space cannot be found in available skilled nursing or intermediate care facilities.

Previous DPW regulations had allowed it to deny reimbursement or to authorize reimbursement in whole or in part when such misutilization of facilities occurred. We held, however, in *Department of Public Welfare v. Temple University* 21 Pa. Commonwealth Ct. 162, 166, 343 A. 2d 701, 704 (1975) (*Temple I*), that:

> "where a patient may no longer be in need of continued acute hospital care but does need some lower level care, . . . it would be an abuse of administrative discretion to deny reimbursement to hospitals which have diligently put forth every effort to locate, without success, an appropriate lesser care facility . . . ."

Subsequently, the DPW adopted the regulation now in dispute, which provides as follows:

> "Except as noted below, Medical Assistance payments are not made to hospitals either for specific noncovered services and procedures or for prolonged hospitalization which is not medically justified.
>
> ". . . .
>
> "Prolonged hospitalization includes extended hospitalization for:
>
> ". . . .
>
> "(q) Patients who no longer require acute patient care. However, the Department will make payment to the hospital for skilled nursing or intermediate care provided for a patient in a certified bed in a certified and approved hospital base skilled nursing or intermediate care unit."
>
> Section 9421.74(q) of the Medical Assistance Manual, 7 Pa. B. 2180.

In essence, therefore, the DPW argues here that it will not now reimburse hospitals for acute care which is not "medically justified" but it will reimburse hospitals for skilled nursing or intermediate care at the rates established for such services but only if the hospital or a part thereof is certified to provide such services. The plaintiffs argue, however, that the currently applicable DPW regulation is (1) in violation of our previous decision in *Temple I*, (2) a violation of the constitutional guarantee of equal protection, (3) beyond the Department's authority, and (4) inconsistent with federal law.

As to our holding in *Temple I*, we decided that it was an abuse of administrative discretion for the DPW to deny reimbursement to a hospital which had made a diligent effort to find a lesser care facility. Under the regulations then in effect, however, the DPW had the discretion to

deny reimbursement. Here, the situation is different because there is no such discretion provided for in the currently applicable regulation. In reality, therefore, it is the manner of reimbursement rather than the refusal to reimburse which is here under attack, and we believe that the issues raised here are not controlled by our decision in *Temple I.*

As to equal protection, the plaintiffs argue that the current regulation distinguishes unreasonably between patients who require acute in-patient hospital care for purely medical reasons and those who receive such care because there is no suitable facility to which they can be transferred. We believe, however, that the regulation treats equally all Medical Assistance patients who require skilled nursing or intermediate care, reimbursement being made only at the rate established for the particular service and only when the care is provided by a certified facility. In addition, if the hospital is certified to provide the lesser care needed, the DPW will reimburse a hospital for patients who do not need acute care but who cannot be transferred. The plaintiffs, here, are unwilling to maintain lesser care facilities, yet they are demanding reimbursement at the rate established for acute care. They have not, however, been deprived of equal protection; on the contrary, the regulation is a reasonable attempt by the DPW to promote legitimate economic interests. Any disparity in reimbursement which results from the *application* of the regulation is brought about by the failure of the plaintiffs to comply with the rational standards for reimbursement which have been prescribed, and can hardly be considered invidious discrimination. "If the classification has some 'reasonable basis,' it does not offend the Constitution simply because the classification . . . in practice . . . results in some inequality." *Dandridge v. Williams,* 397 U. S. 471, 485 (1970) (citations omitted).

As to the argument that the regulation is unreasonable and beyond the DPW's authority in that it attempts to coerce hospitals to operate skilled nursing or intermediate care facilities in order to obtain reimbursement for the patients who do not need acute care, we believe that there is no real coercion or duress here, for the plaintiffs need not participate in the Medical Assistance program at all. *Cf. Temple I, supra.* There is, moreover, no evidence before us that providing the services required would be unduly burdensome to the plaintiffs. In fact, we are informed by affidavit [1] that 29 hospitals in the Comwealth are now certified to provide skilled nursing or intermediate care.[2] We do not believe that the DPW has abused its authority in adopting the regulation in contention, for it is clear that the courts of this Commonwealth may not interfere with an administrative agency's legislative rulemaking power in absence of an abuse of power, *see Steward v. Department of Public Welfare,* 39 Pa. Commonwealth Ct. 530, 395 A. 2d 1043 (1979), and " 'it is not enough that the prescribed system of accounts shall appear to be unwise or burdensome or inferior to another. Error or unwisdom is not equivalent to abuse.' " *Uniontown Area School District v. Pennsylvania Human Relations Commission,* 455 Pa. 52, 77, 313 A. 2d 156, 169 (1973)

1. Affidavit of Michael A. Berchock, Chief of Reimbursement Methods Division, Department of Public Welfare.

2. The plaintiffs have submitted an affidavit which indicates that a majority of these hospitals would not qualify for certification under regulations recently adopted by the Department. This evidence is inconclusive, however, because it does not demonstrate either the difficulty the hospitals had with meeting the previous standards or the difficulty of meeting the new standards. We cannot conclude, therefore, on the basis of this evidence that certification and operation of such facilities is unduly burdensome to the plaintiffs.

(quoting *American Telephone & Telegraph Co. v. United States*, 299 U. S. 232 (1936)).

Finally, as to the plaintiffs' assertion that the regulation in dispute is inconsistent with federal law, we are not convinced that the situation at issue here is covered by federal statute or regulations. While it may be covered under the regulations as to Medicare, to which the plaintiffs attempt to draw an analogy, we are dealing here with Medicaid, and the plaintiffs concede "a deficiency in current HEW regulations as to Medicaid on the subject." In fact, the argument of the plaintiffs can really be reduced to the proposition not that federal law is violated but that reimbursement by the DPW for acute care when a transfer cannot be made would not be inconsistent with federal law. Without considering further the complexities of the plaintiffs' argument, we believe it sufficient to note that they simply have not sufficiently demonstrated any inconsistency between the federal law and the regulation here in question.

We shall therefore deny the plaintiffs' motion for summary judgment.

GENEVIEVE BLATT
Genevieve Blatt, Judge

IN THE
COMMONWEALTH COURT OF PENNSYLVANIA

No. 1171 C. D. 1976

TEMPLE UNIVERSITY—OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION AND THE HOSPITAL ASSOCIATION OF PENNSYLVANIA, ON BEHALF OF ITSELF AND THEMSELVES AND ALL OTHERS SIMILARLY SITUATED,

Plaintiffs

v.

PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE AND HELEN B. O'BANNON, SECRETARY, PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE,

Defendants

ORDER

AND, Now, this 26th day of October, 1979, the motion for summary judgment of Temple University and the Hospital Association of Pennsylvania is denied, and judgment is hereby entered in favor of the Department of Public Welfare and Helen B. O'Bannon.

/s/ GENEVIEVE BLATT
Genevieve Blatt, Judge

CERTIFIED FROM THE RECORD
OCT 26, 1979
FRANCIS C. BARBUSH
Chief Clerk

SUPREME COURT OF PENNSYLVANIA
MIDDLE DISTRICT

No. 68 May Term, 1979

TEMPLE UNIVERSITY OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION, and THE HOSPITAL ASSOCIATION OF PENNSYLVANIA, on behalf of itself and themselves and all others similarly situated,

Appellants

v.

PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE and HELEN B. O'BANNON, SECRETARY, PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE

JUDGMENT

ON CONSIDERATION WHEREOF, it is now here ordered and adjudged by this Court that the Decree of the Commonwealth Court be, and the same is hereby affirmed. Each party to pay own costs.

/s/ MILDRED E. WILLIAMSON
Deputy Prothonotary

Dated: June 19, 1980

IN THE
SUPREME COURT OF PENNSYLVANIA
MIDDLE DISTRICT

No. 68, May Term, 1979

TEMPLE UNIVERSITY—OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION and THE HOSPITAL ASSOCIATION OF PENNSYLVANIA, on behalf of itself and themselves and all others similarly situated,

Appellants

v.

PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE and HELEN O'BANNON, SECRETARY, PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE,

Appellees

NOTICE OF APPEAL TO THE SUPREME COURT OF THE UNITED STATES

Notice is hereby given that Temple University—Of the Commonwealth System of Higher Education and The Hospital Association of Pennsylvania, the appellants above-named, hereby appeal to the Supreme Court of the United States from the final judgment of the Supreme Court of the Commonwealth of Pennsylvania, affirming the Decree of the Commonwealth Court, entered in this action on June 19, 1980.

This appeal is taken pursuant to 28 U. S. C. § 1257(2).

/s/ MATTHEW M. STRICKLER
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Attorneys for Appellant
Temple University—Of the Commonwealth System of Higher Education

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Dated: September 15, 1980

IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1980

No.

TEMPLE UNIVERSITY—OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION,
Appellant

v.

COMMONWEALTH OF PENNSYLVANIA, DEPARTMENT OF PUBLIC WELFARE and HELEN O'BANNON,
Appellees

CERTIFICATE OF SERVICE

Matthew M. Strickler, Esquire, hereby certifies that he is a member of the bar of the Supreme Court of the United States and counsel for Temple University—Of the Commonwealth System of Higher Education, Appellant in the above matter; that on September 15, 1980, a copy of the foregoing Notice of Appeal was served by hand delivery on John A. Kane, Esquire, counsel for the Pennsylvania Department of Public Welfare and Helen O'Bannon, Appellees in the above matter, at his office at Room 323, Health and Welfare Building, Harrisburg, Pennsylvania 17120; and that on the same day a copy was filed with the Commonwealth Court of Pennsylvania by hand delivery to the Prothonotary at his office at 625 South Office Building, Harrisburg, Pennsylvania 17120.

Matthew M. Strickler

Supreme Court, U. S.
FILED
NOV 4 1980
MICHAEL RODAK, JR., CLE

No. 80-422

In the Supreme Court of the United States

October Term, 1980

TEMPLE UNIVERSITY—OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION and THE HOSPITAL ASSOCIATION OF PENNSYLVANIA,
Appellants

v.

COMMONWEALTH OF PENNSYLVANIA, DEPARTMENT OF PUBLIC WELFARE and HELEN B. O'BANNON,
Appellees

On Appeal From the Supreme Court of Pennsylvania

MOTION OF APPELLEES TO DISMISS

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Dated: October 28, 1980

Murrelle Printing Co., Box 100, Sayre, Pa. 18840—(717) 888-2244

COUNTER-STATEMENT OF THE QUESTION PRESENTED

Whether this case presents a substantial federal question for review by this court.

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STATUTES INVOLVED

42 U.S.C. §1396a (a) (13) (B) (C):

(B) in the case of individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, for the inclusion of at least the care and services listed in clauses (1) through (5) of section 1396d (a) of this title, and

(C) in the case of individuals not included under subparagraph (B) for the inclusion of at least—

(i) the care and services listed in clauses (1) through (5) of section 1396d (a) of this title or

(ii) (I) the care and services listed in any 7 of the clauses numbered (1) through (16) of such section and (II) in the event the care and services provided under the State plan include hospital or skilled nursing facility services, physicians' services to an individual in a hospital or skilled nursing facility during any period he is receiving hospital services from such hospital or skilled nursing facility services from such facility, and

42 U.S.C. §1396a (a) (17):

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect

to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter, as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to State eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to

States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;

42 U.S.C. §1396a(a)(23):

(23) except in the case of Puerto Rico, the Virgin Islands, and Guam, provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services; and a State plan shall not be deemed to be out of compliance with the requirements of this paragraph or paragraph (1) or (10) solely by reason of the fact that the State (or any political subdivision thereof) had entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic;

42 U.S.C. §1396a(a)(30):

(30) provide such methods and procedures relating to the utilization of, and the payment for, care and ser-

vices available under the plan (including but not limited to utilization review plans as provided for in section 13-96b (i) (4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care;

42 U.S.C. §1396a (b):

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) . . .

Pa. Stat. Ann. title 62 §§201 (1) and (2) (Purdon):

201. State participation in cooperative federal programs.

The department shall have the power:

(1) With the approval of the Governor, to act as the sole agency of the State when applying for, receiving and using Federal funds for the financing in whole or in part of programs in fields in which the department has responsibility.

(2) With the approval of the Governor, to develop and submit State plans or other proposals to the Federal government, to promulgate regulations, establish and enforce standards and to take such other measures as may be necessary to render the Commonwealth eligible for available Federal funds or other assistance.

Pa. Stat. Ann. title 62 §403 (b) (Purdon):

(b) The department shall establish rules, regulations and standards, consistent with the law, as to eligi-

bility for assistance and as to its nature and extent. The secretary or his designee in writing is the only person authorized to adopt regulations, orders, or standards of general application to implement, interpret, or make specific the law administered by the department. The secretary shall issue interim regulations whenever changes in Federal laws and regulations supersede existing statutes. In adopting regulations, orders, or standards of general application, the secretary shall strive for clarity of language which may be readily understood by those administering aid and by those who apply for or receive aid.

Pa. Stat. Ann. title 62 §443.1 (1) (Purdon):

443.1 Medical assistance payments for institutional care.

The following medical assistance payments shall be made in behalf of eligible persons whose institutional care is prescribed by physicians:

(1) The reasonable cost of inpatient hospital care, as specified by regulations of the department adopted under Title XIX of the Federal Social Security Act and certified to the department by the Auditor General for a bed patient on a continuous twenty-four hour a day basis in a multi bed accommodation of a hospital, exclusive of a hospital or distinct part of a hospital wherein twenty-five percent of patients remain six months or more. To be eligible for such payments a hospital must be qualified to participate under Title XIX of the Federal Social Security Act and have entered into a written agreement with the department regarding matters designated by the secretary as necessary to efficient admin-

istration, such as hospital utilization, maintenance of proper cost accounting records and access to patients' records. Such efficient administration shall require the department to permit participating hospitals to utilize the same fiscal intermediary for this Title XIX program as such hospitals use for the Title XVIII program;

REGULATIONS INVOLVED

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42 C.F.R. §440.40 (a) (1):

Skilled nursing facility services for individuals age 21 or older (other than services in an institution for tuberculosis or mental diseases). EPSDT, and family planning services and supplies.

(a) Skilled nursing facility services.

(1) "Skilled nursing facility services for individuals age 21 or older, other than services in an institution for tuberculosis or mental diseases," means services that are

(i) Needed on a daily basis and required to be provided on an inpatient basis under §§405.127, 405.128, and 405.128a of this chapter;

(ii) Provided by a facility or distinct part of a facility that is certified to meet the requirements for participation under subpart C or part 442 of this subchapter, as evidenced by a valid agreement between the medicaid agency and the facility for providing skilled nursing facility services and making payments for services under the plan; and

(iii) Ordered by and under the direction of a physician.

42 C.F.R. §440.150 (d) :

Intermediate care facility services, other than in institutions for tuberculosis or mental diseases.

(d) "Intermediate care facility services" may include services provided in a distinct part of a facility other than an intermediate care facility if the distinct part

(1) Meets all requirements for an intermediate care facility;

(2) Is an identifiable unit, such as an entire ward or contiguous ward, a wing, floor, or building;

(3) Consists of all beds and related facilities in the unit;

(4) Houses all recipients for whom payment is being made for intermediate care facility services, except as provided in paragraph (e) of this section;

(5) Is clearly identified; and

(6) Is approved in writing by the survey agency.

COUNTER-STATEMENT OF THE CASE

Appellants, Temple University—of the Commonwealth System of Higher Education (Temple University) and The Hospital Association of Pennsylvania, have appealed the judgment of The Supreme Court of Pennsylvania entered on June 19, 1980, and reported at Pa. , 415 A.2d 413 (1980). The Supreme Court there affirmed the decision of the Commonwealth Court, reported at 47 Pa. Commonwealth Ct. 22, 407 A.2d 92 (1979), which held that Appellees' manner of reimbursement to hospitals for care provided to patients who no longer require acute inpatient care but rather skilled nursing or intermediate care but who cannot be transferred immediately to another facility, is reasonable and consistent with applicable Federal and State law.

Appellants seek to invoke this Court's jurisdiction pursuant to 28 U.S.C. §1257(2) by asserting that their appeal involves a substantial federal question. To this end Appellants argue that Appellees reimbursement policy is inconsistent with federal law and is violative of the constitutional guarantee of equal protection.

Appellees, Commonwealth of Pennsylvania, Department of Public Welfare, and Helen B. O'Bannon, Secretary, Department of Public Welfare, here move to dismiss the instant appeal pursuant to Supreme Court Rule 16(b), because it does not present a substantial federal question.

The issue presented to the State courts was the validity under state and federal law of Pennsylvania Medical Assistance Manual Section 9421.74(q). Appellants' argu-

ment before the State courts has been that the regulation is beyond the Appellees' authority to adopt; violates the constitutional guarantee of equal protection of the laws; and is inconsistent with applicable federal law. Appellants have maintained that notwithstanding a medical determination that a patient no longer requires acute inpatient hospital care but rather requires skilled nursing or intermediate care, a hospital is entitled to receive reimbursement at its acute care rate for so long as the patient remains in the hospital.

Appellees have implemented a reimbursement mechanism, which mechanism is set forth in its approved State Plan, whereby a hospital which has a unit certified as a skilled nursing or intermediate care nursing unit can be reimbursed, albeit at a rate that is lower than the hospital's acute care rate, for the care provided to Medical Assistance eligible recipients who no longer require acute inpatient hospital care.[1] While challenging the Appellees' reimbursement system, Appellants, in their original complaint filed with the Commonwealth Court below, admitted that the inability of a hospital to transfer a patient to a lesser level care institution occurred from but "time from

[1] States are not required to institute a Medicaid Program, but if they choose to do so, they must submit to the Department of Health and Human Services (HHS) a satisfactory "State Plan" which fulfills all the requirements of Title XIX of the Social Security Act, 42 U.S.C. §1396 *et seq.* See 42 U.S.C. §1396a. The Secretary of HHS must approve a Plan which meets all requirements of the statute and implementing regulations. 42 U.S.C. §1396a(b). The State thereupon becomes entitled to grants of federal funds in reimbursement for a portion of the expenditures which it makes in providing specific types of Medical Assistance to eligible individuals under the Plan.

time". Appellants have argued that they are entitled to reimbursement at the acute care rate and cannot be required to establish certified units as a prerequisite to obtaining reimbursement.[2]

---

[2] At the time the case was before the state courts, the acute care rate at Temple University Hospital was $265.00 per day. The per diem rate for hospital based units was $42.00 per day for operating costs, depreciation costs being reimbursed separately.

Argument

THIS CASE DOES NOT PRESENT A SUBSTANTIAL FEDERAL QUESTION

A. Operation of the Medicaid Program

Title XIX (Medicaid) provides for the establishment of a cooperative Federal-State Program to provide payments for medical services rendered to certain needy individuals whose income and resources are insufficient to meet the costs of these services. Participation in the Medicaid Program by a State is voluntary, but in order to qualify for federal funds, the State's Program must meet certain federal requirements. 42 U.S.C. §1396a. The State must have an approved State Plan which meets all the requirements of the statute and implementing regulations. 42 U.S.C. §1396a(b). The State thereupon becomes entitled to grants of federal funds and reimbursement for a portion of its expenditures in providing specific types of medical assistance to eligible individuals under the plan in accordance with federal requirements. 42 U.S.C. §1396b. Pennsylvania participates in the Medicaid Program under an approved State Plan.

It is the States which actually administer the individual State plans, and, within the scope of Title XIX, there is much room for the States to design their own programs. The introductory section of Title XIX sets forth the general statement of purpose of the Act and clearly expresses the broad flexibility Congress intended to give

the States in developing and administering Medical Assistance Programs.

> "§1396. Authorization of appropriations.
>
> For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals whose income and resources are insufficient to meet the costs of necessary medical services, ..."

Furthermore, in *Beal v. Doe,* 432 U.S. 438, 441 (1977), this Court, in deciding whether a State Plan which denied funds for abortions unless they were certified by a physician as "medically necessary" was violative of Title XIX, held:

> Although Title XIX does not require States to provide funding for all medical treatment falling within the five general categories it does require that State Medicaid plan establish 'reasonable standards . . . for determining . . . the extent of medical assistance under the plan which . . . are consistent with the objectives of [Title XIX].' 42 U.S.C. §1396a (a) (17) (1970 ed., Supp. V).

This Court emphasized that the Act confers broad discretion on the States to adopt standards for determining the extent of medical assistance, requiring only that such standards be reasonable and consistent with the objectives of Title XIX. *Beal v. Doe,* 432 U.S. at 444. See also, *Preterm, Inc. v. Dukakis,* 591 F.2d 121 (1st Cir. 1979), *cert. denied, Baird v. Pratt,* U.S. , 99 S.Ct. 2181 (1979). Appellees submit that §9421.74 (q) neither conflicts with Federal law nor denies equal protection.

B. Pennsylvania Medical Assistance Regulation 9421.74 (q) Does Not Conflict With Title XIX of the Social Security Act

The administrative regulation at issue in this case is Pennsylvania Medical Assistance Regulation 9421.74 (q). Section 9421.74 (q) was adopted by the Pennsylvania Department of Public Welfare (DPW) pursuant to its delegated legislative rulemaking authority as set forth at Sections 201 (1) and (2), 403 (b) and 443.1 (1) of the Public Welfare Code (Pa. Stat. Ann. title 62, §§201 (1) and (2), 403 (b), 443.1 (1) (Purdon)). Section 9421.-74 (q) is part of the regulatory scheme that implements Pennsylvania's federally approved State Plan for Medical Assistance. The State Plan establishes different classes of nursing care facilities.[3] Under Section 9421.74 (q) skilled and intermediate nursing care services provided by a hospital that has an effective nursing care provider agreement[4] are reimbursed for as long as the services are medically necessary.

Appellees through the adoption of §9421.74 (q), have implemented a medical assistance program delivery and reimbursement scheme that is consistent with federal law governing the types of inpatient hospital services which may be provided, i.e., acute care and skilled or interme-

[3] These classes are: general (privately owned) nursing facilities; public (county owned) nursing facilities; intermediate care facilities for the mentally retarded; psychiatric transitional facilities for the mentally ill; and hospital-based facilities.

[4] Federal Regulations provide for the creation of hospital based distinct part nursing care units. 42 C.F.R. §§440.40(a)(1) and 440.150(d).

diate nursing care in a distinct part of a hospital. See 42 C.F.R. §§440.10, 440.40 and 440.150. Appellees have followed the federal mandate that they provide for methods and procedures intended to safeguard against payments for services which are in excess of reasonable charges consistent with efficiency, economy, and quality of care, and that services be provided by a facility certified to provide the service, by distinguishing between the three different levels of reimbursement to hospitals for the care actually needed by individual patients. See 42 U.S.C. §1396a(a)(17) and (30).

As evidenced by reference to applicable federal regulations, these distinctions are consistent with federal law and have been implemented pursuant to an approved State Plan. The fact that the Plan has obtained such approval is significant in that great deference is to be given to interpretations of regulations by the agency charged with the administration of the statute. See, *New York State Department of Social Security v. Dublino,* 413 U.S. 405, 421 (1973); *Red Lion Broadcasting v. FCC,* 395 U.S. 367 (1969). Approval by HHS of the current State Plan, providing as it does, for distinct part hospital based nursing care facilities, certifies that the Plan, from the perspective of HHS, is consistent with applicable law.

Appellants contend, however, that this system violates the provisions of 42 C.F.R. §440.230(b) and (c) in that Appellees arbitrarily have denied or reduced services to otherwise eligible recipients. Indeed, Appellants allege that the importance of the issue presented here for review is the need for the Court to render a definitive statement of the legal standard which all States must follow in determining which services they are required to provide under

the Medicaid Program.[5] Even assuming that a service reduction was involved here, no such statement by this Court is necessary. Those courts which have been presented with disputes concerning a state's authority to reduce services under a public service program, such as Medicaid, have recognized the state's right to establish priorities within the constraints of State and federal appropriations so long as the services provided are sufficient to reasonably achieve the purpose of the program. *Beal v. Doe, supra; Quern v. Mandley,* 436 U.S. 725 (1978); *Curtis v. Taylor,* Nos. 78-2203, 79-2244 (5th Cir. Sept. 11, 1980); *Zbraz v. Quern,* 596 F.2d 196 (7th Cir. 1979); *Preterm Inc. v. Dukakis,* 591 F.2d 121 (1st Cir. 1979), *cert. denied, Baird v. Pratt,* U.S. , 99 S.Ct. 2181 (1979); *Doe v. Colautti,* 592 F.2d 704 (3d Cr. 1979). As there have been no conflicting decisions in this area of the law, Appellants' description of the issue as being of "central importance" is a gross misstatement.

Appellants' misperception of the case law in this area aside, the provisions of 42 C.F.R. §440.230(b) and (c)

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[5] Appellants contend that the decision in *White v. Beal,* 555 F.2d 1146 (3d Cir. 1977) conflicts with that of the Pennsylvania Supreme Court in this case, thus raising an independent reason for the Court to assume jurisdiction. Appellees suggest that *White v. Beal* is inapposite to the issue presented here. At one time, eyeglasses were covered under the Pennsylvania Medical Assistance Program only to correct vision impaired by eye disease. Persons with refractive error were not eligible for eyeglasses. This distinction was held to be contrary to the express provisions of 42 C.F.R. 440.230(c)(1). No such disparity exists under the state regulation at issue below. *All* Medical Assistance recipients are eligible for acute hospital care, for skilled nursing care and for intermediate care from certified providers of such services.

simply are not relevant to this case. The manner of reimbursement utilized by the Appellees permits them to assure the delivery of acute inpatient hospital care, skilled nursing care, and intermediate care in their entirety to the Medicaid population as a whole while simultaneously working in a responsible manner to maintain the fiscal solvency of the Pennsylvania Medical Assistance Program. This manner of reimbursement is consistent with the letter of Title XIX as well as with the case law that has developed concerning implementation of that statute. 42 U.S.C. §§1396, 1396a(a)(17), 1396a(a)(30); *Beal v. Doe, supra; Preterm Inc. v. Dukakis, supra; Doe v. Colautti, supra, Medical Society of New York v. Toia,* 560 F.2d 535 (2d Cir. 1977); *Virginia Hospital Association v. Kenley,* 427 F. Supp. 781 (E.D. Va. 1977); *District of Columbia Podiatry Society, et al. v. The District of Columbia,* 407 F. Supp. 1259 (1975); *Monmouth Medical Center v. State of New Jersey,* 80 N.J. 299, 403 A.2d 487 (1979). See also the legislative history of the 1972 amendments to Title XIX which is replete with expressions of congressional concern for these goals. (1972 U.S. Code Cong. & Ad. News 4982, 4994, 5001-5007, 5008, 5060, 5075, 5086-5087).

Appellants, of course, have conceded there is no continuing need for acute inpatient hospital care for the patients for whom reimbursement has been disallowed under §9421.74(q). It necessarily follows from this admission that the coverage provided for acute care is sufficient to reasonably achieve its purpose.

With respect to patients who require skilled or intermediate nursing care, including those patients who no longer require acute inpatient care, the Department reim-

burses the delivery of those services provided by a facility that has an effective nursing care provider agreement with the Department *for as long as the services are medically necessary.* These nursing care services may be provided by a free-standing nursing care facility that is certified and that is operated by a local county government, a private profit or non-profit corporation, or by a hospital with a certified distinct part nursing care unit.

The Department submits that insofar as the majority of Medicaid eligible patients are concerned, this system provides adequate coverage to meet their needs. Indeed, Appellants themselves admit in Paragraph 12 of their Complaint in Equity, that any difficulty they experience in placing former acute care patients into non-acute care beds occurs only from "time to time".

Appellants, unable to establish any inconsistencies between federal statute or regulation and the state regulation at issue, also attempt to convince this Court that the New Jersey Supreme Court has taken a position inconsistent with that of Pennsylvania on the same issue. This argument too is unpersuasive. In *Monmouth Medical Center v. State of New Jersey, supra,* the New Jersey Supreme Court was presented with a state regulation that denied hospitals reimbursement for services rendered while patients were awaiting transfer to lesser level of care facilities. Unlike the present case, however, the New Jersey regulations made *no provision* whatsoever for a hospital to obtain reimbursement for the care it provided to patients pending their transfer to alternative health care facilities.

Although recognizing and sympathetic to the state's legitimate interest in allocating limited resources in the

most efficient manner possible and in discouraging over-utilization of hospital facilities, the court held that the regulation unreasonably denied reimbursement to those hospitals which, due to conditions beyond their control, could not transfer their patients to a skilled or an intermediate nursing care facility.

Although the court invalidated the regulation, it did so on the basis that the regulation failed to provide *any* mechanism whereby the hospital could be reasonably reimbursed for the nursing care services rendered. The Court then defined what it considered to be the equitable solution to the matter:

> [W]e note that the obvious equitable solution would be to reimburse hospitals in such circumstances at a rate commensurate with that of the lesser care facility which could provide the needed services. *Monmouth Medical Center v. State of New Jersey,* 403 A.2d at 493.

The only difference between the solution advocated by the New Jersey Supreme Court and Regulation 9421.-74(q) is that if Appellees are to assure federal financial participation (approximately 55% of the service cost) for services provided to a non-acute care patient in a hospital, the hospital must have a certified nursing unit. See 42 C.F.R. §§440.40(a)(1); 440.150(d). Pursuant to the mandate in Section 201(1) of the Pennsylvania Public Welfare Code, Pa. Stat. Ann. title 62, §201(1) (Purdon), that the Department do all things necessary to obtain federal funding, and as a matter of sound administrative judgment, the Department requires that a hospital establish such a unit if it is to qualify for Medicaid reimbursement.

In sum, Appellants have failed to cite to any federal law or to any federal or state court decision that even remotely supports their contention. To the contrary, there are no statutes to be interpreted, no conflicting decisions among the circuits to be resolved and no novel or important principles of law presented by this case which merit review by this Court.

C. Section 9421.74(q) Does Not Deny to Medical Assistance Patients Equal Protection of the Law as Guaranteed by the Fourteenth Amendment to the United States Constitution

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Appellants also assert that the Pennsylvania Medical Assistance Program has created, through §9421.74(q) a category of persons who somehow are distinguishable from other persons who are eligible for Medical Assistance. In particular, the "class" would consist of hospital patients who no longer require acute inpatient care, but who are in need of skilled or intermediate nursing services and for whom no lesser level of health care facility is available.

Pennsylvania submits that a separate category of Medical Assistance patients has not been established by this regulation. More correctly, the regulation applies uniformly to all persons who are eligible for Medical Assistance benefits. In that respect the regulation is one of "general applicability" and satisfies the equal protection principle without further inquiry. "General rules that apply evenhandedly to all persons within the jurisdiction unquestionably comply with this principle. Only when

a governmental unit adopts a rule that has a special impact on less than all the persons subject to its jurisdiction does the question whether this principle is violated arise." *New York City Transit Authority v. Beazer,* 440 U.S. 568, 587-588 (1979). As applied, §9421.74(q) neither diminishes nor abolishes an eligible recipient's entitlement either to acute inpatient services or to skilled care or intermediate nursing services from a certified provider.

In this case, a benefit has not been denied to some persons who are otherwise similarly situated, while granted to others. What Appellants fail to recognize is that §9421.74(q) does not diminish a recipient's entitlement to necessary care. Under Title XIX, eligible recipients are only entitled to the receipt of *covered* services from certified providers of those services. 42 U.S.C. §§1396, 1396a(a)(23). Thus if an otherwise eligible Medical Assistance recipient receives medical care from a provider that does not participate in the Medical Assistance program, the care rendered to that person will not be reimbursed by the Medical Assistance program. Indeed, there may be any number of otherwise Medical Assistance eligible persons whose care will not be reimbursable until such time as they are treated by a certified provider. Payment for medical care of any kind under the Medical Assistance program is not based wholly on the need of the client, but depends as well on the type of service provided and the eligibility of the provider.

The Social Security Act provides that the purpose of the Medicaid Program is to enable each State "as far as practicable under the conditions in such State" to furnish medical assistance to certain needy individuals. 42 U.S.C. §1396a. The general criteria for eligibility under the pro-

gram are that the recipient be eligible for coverage, that the service be provided under the program, and that the provider be certified to provide the service. These general criteria apply equally to all recipients with respect to all services.

Here the patients awaiting transfer to another facility are not being denied a service that otherwise eligible persons in need of nursing care are being provided. These patients are not being denied service from a provider who is simultaneously providing the same service to other medical assistance recipients. Likewise, these patients are not being denied a service available to persons with the same needs due to a discriminatory application of eligibility criteria. Regardless of the medical necessity for the service, a Medicaid recipient is not entitled to receipt of a service under the Medical Assistance Program when the service is provided by a non-certified provider.

To the extent that patients awaiting transfer to another facility are denied coverage for non-acute care services provided, they are treated no differently than any other medical assistance recipient. Conversely, to the extent that Medicaid eligible persons receive care from a certified provider of skilled nursing or intermediate care services, those persons, and the acute care patients awaiting transfer, are not similarly situated. In neither case is there a violation of the equal protection clause.

CONCLUSION

Wherefore, Appellees respectfully submit that the question upon which this appeal depends is so unsubstantial as not to need further argument, and Appellees respectfully move the Court to dismiss this appeal.

Respectfully submitted,

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IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1980
No.

TEMPLE UNIVERSITY—OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION,

Appellant

v.

COMMONWEALTH OF PENNSYLVANIA, DEPARTMENT OF PUBLIC WELFARE and HELEN O'BANNON

Appellees

CERTIFICATE OF SERVICE

Jonathan Vipond, III, Esquire, hereby certifies that he is a member of the bar of the Supreme Court of the United States and counsel for the Commonwealth of Pennsylvania, Department of Public Welfare and Helen O'Bannon, Appellees in the above matter; that on November 3, 1980, three copies of Appellees' Motion to Dismiss were mailed, first class, pre-postage paid to Matthew M. Strickler, Esquire, 30 South 17th Street, Philadelphia, PA 19103, counsel for Appellant, Temple University, and to Roland Morris, Esquire, 1600 Land Title Building, Philadelphia, PA 19110, counsel for Appellant, The Hospital Association of Pennsylvania.

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No. 80-422

IN THE

Supreme Court of the United States

October Term, 1980

TEMPLE UNIVERSITY—OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION and THE HOSPITAL ASSOCIATION OF PENNSYLVANIA,

Appellants

v.

COMMONWEALTH OF PENNSYLVANIA, DEPARTMENT OF PUBLIC WELFARE and HELEN O'BANNON,

Appellees

On Appeal From the Supreme Court of Pennsylvania

BRIEF IN OPPOSITION TO MOTION OF APPELLEES TO DISMISS

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ARGUMENT

Because most of the issues raised by the Motion of Appellees to Dismiss were anticipated in the Jurisdictional Statement, this brief will be limited to clarifying a few points which are central to the issues presented:

1. Appellants challenge the Department's Regulation 9421.74(q) because it forbids payment for inpatient hospital care which is necessary because there is no nursing home bed to which the patient can be transferred. Appellants do not maintain, as suggested at page 9 of the Motion, that a hospital is entitled to payment, in every case, for as long as the patient remains in the hospital.

2. The Motion suggests (page 18) that a state may receive federal financial assistance to pay a hospital for overstay care only if that hospital operates a separate nursing home facility. This is true *only if* payment is to be made at a nursing home rate. Federal financial assistance is, however, available to pay a hospital for custodial care at the inpatient hospital rate whether or not that hospital operates a nursing home. Moreover, because a hospital is paid for all inpatient days at its average per diem cost, a hospital must be paid for the overstay days at the full inpatient rate, if it is to be paid the total cost of all of its inpatient care. (See Jurisdictional Statement, p. 11, fn. 13).

3. The Motion attempts to distinguish *Monmouth Medical Center v. State of New Jersey*, 80 N. J. 299, 403 A. 2d 487 (1979) by pointing out that the specific New Jersey regulation challenged there made no provision for payment to a hospital-based nursing home. There is, however, no effective difference between that case and this

because New Jersey, like Pennsylvania, pays for care in hospital-based nursing homes.

4. The Motion attempts to justify Regulation 9421.74 (q) on the ground that overstay patients are not receiving care from a certified provider. This is not so. Even though the patients' condition would permit a lesser level of care, they are receiving inpatient hospital care from a certified hospital. These overstay days are counted in determining the per diem rate which the hospital receives for all of its patient days.

5. Most importantly, appellees studiously ignore that their Regulation 9421.74(q) precludes payment for medically necessary inpatient care [1] which hospitals are required to provide. Thus, they ignore the central issue which this Court has not resolved (*see Beal v. Doe*, 432 U. S. 438, 444 (1975)) and which has been the focus of discussion of the other courts which have wrestled with this problem.[2]

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1. This holding in prior litigation between Temple University and the Department is binding on appellees. *Commonwealth of Pennsylvania, Department of Public Welfare v. Temple University—Of the Commonwealth System of Higher Education*, 21 Pa. Commw. Ct. 162, 166, 343 A. 2d 701, 704 (1975).

2. In addition to the cases cited in footnote 12 at page 10 of the Jurisdictional Statement, two recent decisions of the Fifth Circuit have applied a standard based on medical necessity. *Curtis v. Taylor*, 625 F. 2d 645 (September 11, 1980) and *Rush v. Parham*, 625 F. 2d 1150 (September 15, 1980).

CONCLUSION

For the reasons stated in the Jurisdictional Statement and herein, this Court should note probable jurisdiction of this appeal.

Respectfully submitted,

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